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Key Messages

- The preliminary evidence shows mental health benefits for individuals who completed the mental health intervention as part of a Community Sentence Treatment Requirement (CSTR). Data were collected as part of a national multi-site evaluation being completed by the Institute for Public Safety, Crime and Justice, based at the University of Northampton.
- Assessment data were provided by local health teams for **493** individuals, of who **208** had started the intervention and **105** had completed the intervention. This policy paper focuses on health change following intervention with breach rates and non-completion data not being presented.
- For cases where both pre-intervention and post-intervention data were provided, statistically significant positive change was identified for all measures, demonstrating efficacy and the importance of efforts to increase CSTRs nationally:
    - ***Global distress*** measured using CORE-34 on average was scored **65.6** at the start of intervention (moderate psychological distress) to **40.0** at the end of intervention (mild psychological distress).
    - ***Anxiety*** measured using GAD-7 on average was scored **13.5** at the start of intervention (moderate anxiety) to **8.7** at the end of intervention (mild anxiety).
    - ***Depression*** measured using PHQ-9 on average was scored **14.9** at the start of intervention (moderate depression) to **9.6** at the end of intervention (mild depression).
- Overall, the preliminary evidence demonstrates how most individuals experience a significant positive change following intervention, suggesting that MHTR programmes are very promising. As the evaluation progresses, links between such health gains and reoffending will be explored. However, the policy paper provides some evidence to support and consider further expansion of CSTR programmes nationally.

What is the problem?

The proportion of Community Sentences Treatment Requirements (CSTRs), especially Mental Health Treatment Requirements (MHTRs), as part of Community Orders or Suspended Sentence Orders has been very low. This coupled with significant mental health needs of offenders alongside rising concerns about the effectiveness of short-term sentences establishes the importance of offering a positive alternative to address underlying needs. Until recently, there has been limited evidence that demonstrates the effectiveness of MHTRs at improving health outcomes to reduce likelihood of reoffending.

Introduction

The purpose of this Policy Brief is to explore health outcomes for individuals who complete a mental health intervention as part of a CSTR. It provides a summary of health outcomes and measured change using a range of psychometric measures. Data were provided from a national multi-site evaluation being completed by the Institute for Public Safety, Crime and Justice, based at the University of Northampton, and were from the following sites: Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Northamptonshire and Staffordshire.

What are Mental Health Treatment Requirements?

Mental Health Treatment Requirements (MHTRs) sit alongside Drug Rehabilitation Requirement (DRR) and Alcohol Treatment Requirement (ATR) under the umbrella of 'Community Sentence Treatment Requirements' (CSTR). They were introduced in their current form in 2003 in England and Wales to enable Judges and Magistrates to tailor sentences according to the nature of the offence and the offender. It is recognised that CSTRs have been used in very few cases, despite evidence of high proportions of convicted offenders presenting with mental health conditions, and drug and alcohol misuse.

MHTRs may be used in relation to any mental health issue, including personality disorders and neurodevelopmental disorders. MHTRs can be provided by a broad range of Clinicians as long as the requirement is clinically supervised by or under the supervision of a suitably specialist registered medical practitioner or registered psychologist (CJA, 2003). The MHTR is intended as a sentencing option for offenders who suffer from a low to medium level mental health problem which is assessed as being suitable for a mental health intervention in the community. Specifically, this means those offenders who do not require secure in-patient treatment and whose

offending behaviour may be positively affected by mental health intervention in the community. This will be dependent upon the recommendations of the mental health assessment.

As established pathways and provision within different sites emerge, a focus for many is to reduce short-term sentencing especially for women. Women who offend are typically given a short sentence due to the circumstances and nature of the offence, with 62% of sentenced women entering prison in 2017 serving six months or less (Prison Reform Trust 2018). It should also be noted that women are more likely to be the victims of crime than male offenders, with experience of domestic abuse, child abuse, sexual violence and sexual exploitation being common for female offenders.

What does the mental health intervention involve?

The MHTR intervention involves 10-12, 50-minute sessions across the Community Order as specified by the Court, where the individual meets with the Primary Care MHTR Practitioner under supervision of the Clinical Lead. The timing of sessions within the Community Order will be determined in the Post Sentence Case Management Meeting, considering other requirements and their interdependencies.

The interventions will be individually tailored to the needs of each client and therefore will vary within and between sites. Critically, the content of each intervention should be determined in respect of issues and needs identified in the MHTR Practitioner Assessment as well as issues and needs that are identified through practice. The intervention may typically involve skills and techniques from the following:

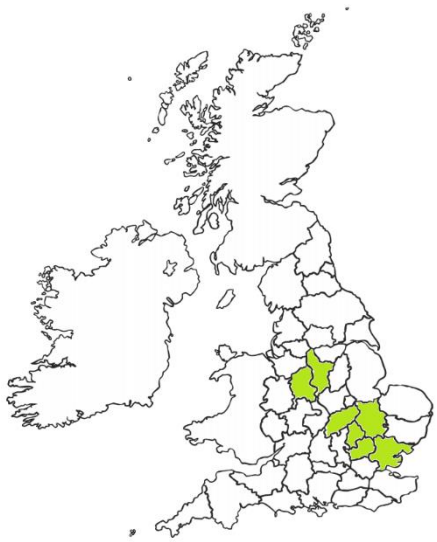
- Psycho education, breathing, mindfulness;
- Compassion focused therapy;
- DBT, CBT, behavioural activation;
- Acceptance and commitment therapy (ACT);
- Mindful practices; and
- Value based solution focused therapy.

About the Evaluation

The evaluation began formally on August 1st 2020 and will last 3 years. It involves 4 key activities in each site:

- Interviews with individuals who receive mental health interventions;
- Interviews with professionals working across MHTR pathway;
- Secondary data analysis of process data; and
- Analysis of outcomes and reoffending.

There are currently 7 sites involved in the evaluation. The evaluation has been reviewed by the University of Northampton Research Ethics Committee, the National Health Research Authority and the National Research Committee. Each site receives a bespoke report every 6 months throughout the project.



Exploring Health Outcomes

The first analysis point in the evaluation was reported in March 2021, which focused on and compared outcomes for individuals assessed for MHTR after 1st July 2020 and before 31th January 2021. The following analysis includes data from this period as well as pre-existing data (i.e. before 1st July 2020) from evaluation sites to identify change between the first and final session of the intervention. Data were collected by the Assistant Psychologists in each site as part of practice.

Assessment and Start of Intervention

In total, there were 493 cases provided in the dataset for MHTR which included a date of assessment and, of those, 208 have started the intervention. Of individuals who started the mental health intervention,

- 69% were female and 31% male. It should be noted that some sites included females exclusively;
- the age of cases ranged between 18 and 67 years, with the average being 36 years of age;
- ethnicity was not recorded for 61 cases, which equates to 29% of the sample. Of those

remaining, 130 (88%) were from a white background, 6 (4%) were from a 'mixed' ethnic background, 5 (3%) were Asian, 5 (3%) were black and 1 (1%) was from an 'other' background;

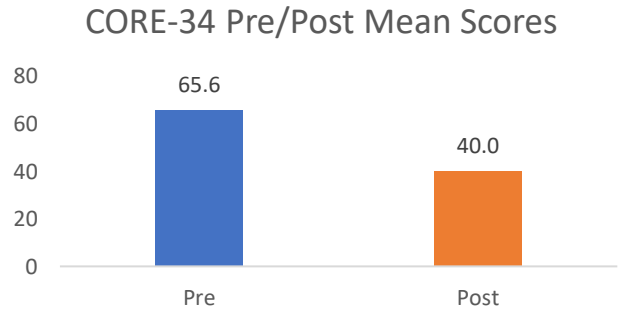
- the most frequent offence type was violence against the person, motoring offences (include driving under the influence) and theft; and
- a range of additional vulnerabilities identified for individuals being sentenced to MHTR in addition to mental health, including abuse, trauma and substance misuse.

Global Distress

Global distress is measured using the CORE-34 - a generic measure of psychological distress across four domains: wellbeing (4 items); problems/symptoms (12 items); life functioning (12 items) and risk (6 items). Higher scores indicate higher levels of general psychological distress. Scores can be interpreted into the following levels:

- Scores 1-20 are likely to be healthy;
- Scores 21-33 are likely to be low level psychological distress;
- Scores 34-50 are likely to be mild psychological distress;
- Scores 51-67 are likely to be moderate psychological distress;
- Scores 68-84 are likely to be moderate-to-severe psychological distress; and
- Score 85+ are likely to be severe psychological distress.

There were 68 cases with pre and post scores on the Core-34. The average pre score was 65.6 (at the higher end of moderate psychological distress) and the average post score was 40.0 (which denotes mild psychological distress. Therefore, the average reduction was -25.6 and this difference was statistically significant t(67) = 7.877, p<0.05.

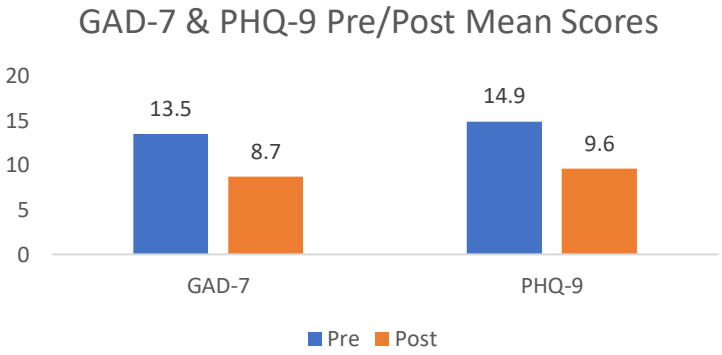


Anxiety

Anxiety is measured using the GAD-7 – a 7-point measure for generalised anxiety disorder (GAD). Scores for each measure are assessed between 0-3 and overall results are interpreted into the following levels:

- Score 0-4 Below Mild Anxiety;
- Scores 5-9 Mild Anxiety;
- Scores 10-14 Moderate Anxiety; and
- Scores 15+ Severe Anxiety.

There were 95 cases with pre and post GAD-7 scores, the average pre-GAD-7 score for this group was 13.5 (Moderate Anxiety) and the average post score was -8.7 (indicating mild anxiety). Therefore, the average reduction was -4.789 and this difference was statistically significant t (94) = -7.728 and p<0.05.



Depression

The next measure used was the PHQ-9 - Patient Health Questionnaire. The PHQ-9 is a brief depression severity measure, where scores for measure are assessed between 0 -3, with higher scores indicating higher severity of depression. Scores are interpreted into the following levels:

- Scores 0 – 4 No Depression
- Scores 5 – 9 Mild Depression
- Scores 10 – 14 Moderate Depression
- Scores 15 – 19 Moderately Severe Depression
- Scores 20+ Severe Depression

There were 47 cases with pre and post scores on the PHQ-9. The average pre-score was 14.9 (moderate depression) and the average post score was 9.6 (mild depression). Therefore, the average reduction was -5.21 and this difference was statistically significant t (46) = 4.909, p<0.05.

Discussion and Implications

The results presented in this paper indicate that the mental health interventions are effective at improving health outcomes for individuals sentenced to MHTRs. As we build the evidence base, associations between outcomes and other factors such as demographics will be explored, providing evidence of what works and for who.

There are challenges at establishing a reliable picture of compliance and completion, as the data set continues to develop across sites. Further work will be completed to assess compliance and engagement within defined time periods in the future to resolve this. An important line of future enquiry will be offending outcomes for individuals who have completed mental health intervention, with insufficient evidence available at present. However, existing evidence suggests that improved health outcomes should lead to lower recidivism.

The analysis presented in this policy paper demonstrates how mental health interventions delivered as part of a CSTR have mental health benefits for individuals who complete an MHTR, with statistically significant benefits being identified for global distress, anxiety and depression.

Therefore, the evidence presented suggests MHTRs may offer a positive alternative to short-term custodial sentences, improving the health of individuals sentenced and addressing a largely unmet need within the offender population.

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